TITLE 9. HEALTH SERVICES

CHAPTER 11. DEPARTMENT OF HEALTH SERVICES HEALTH CARE INSTITUTIONS: RATES AND CHARGES

Editor's Note: The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 03-2).

Chapter 11, consisting of Article 1 (Sections R9-11-101 through R9-11-109) and Article 2 (Sections R9-11-201 and R9-11-202) adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the regulator rulemaking process, the Chapter is printed on blue paper.

Chapter 11, consisting of Article 1 (Sections R9-11-101 through R9-11-121), Article 2 (Sections R9-11-201 through R9-11-213), and Article 3 (Section R9-11-301) repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

ARTICLE 1. GENERAL

Article 1, consisting of Sections R9-11-101 through R9-11-109, adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Article 1, consisting of Sections R9-11-101 through R9-11-121, repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Section

ARTICLE 2. UNIFORM ACCOUNTING SYSTEM

Article 2, consisting of Sections R9-11-201 and R9-11-202, adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Article 2, consisting of Sections R9-11-211 through R9-11-213, repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Section

ARTICLE 3. HOSPITAL DISCHARGE REPORTING FOR INPATIENTS

Article 3, consisting of Section R9-11-301 and R9-11-302, adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

Article 3, consisting of Section R9-11-301, repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Section

ARTICLE 4. OUTPATIENT SERVICES REPORTING

Article 4, consisting of Sections R9-11-401 and R9-11-402, made by final rulemaking at 9 A.A.R. 2105, effective June 3, 2003 (Supp. 03-2).

Section

ARTICLE 1. GENERAL

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-101. Definitions

A. "Accrual" means recording revenues and expenses when incurred with specific periods of time, such as a month or year, without regard to the date of receipt or payment of cash.
B. "Affiliated Organization" means the same as "related party".
C. "Annualized" means data for any period adjusted to represent a 12-month time period.
D. "Charge Code" means a numeric or alpha-numeric identifier assigned by the health care institution to a unit of service such as a procedure, test, or commodity for which a separate charge is levied to a patient and used for identification on a patient's itemized bill.
E. "Charity Allowances" means reductions in charges for services made by the health care institution because of the indigence of the patient. This does not include Title XIX Arizona Health Care Cost Containment Service (AHCCCS) or any other third- party payor settlements.
F. "Department" or "DHS" means the Department of Health Services.
G. "Direct costs" means those costs which are incurred by and charged directly to the revenue-producing departments of the institution.
H. "Director" means the Director of the Department.
I. "Durable Medical Equipment" means reusable equipment a health care institution makes available for patient services. The equipment can be sold, rented or furnished at no cost to a patient.
J. "Expendable" means those non-reusable commodities that may be sold to and are consumed by the patient.
K. "Formula" means a defined mathematical progression applied to the cost of a product to calculate a patient charge.
L. "Health care institution" or "institution" means every place, building or agency, whether organized for profit or not, which provides medical services, nursing services, or health-related services, except those institutions exempted by A.R.S. § 36-402.
M. "Indirect costs" means those costs which are incurred by and charged directly to the non-revenue-producing departments and then are proportionately allocated to the revenue-producing departments of the institution.
N. "Inpatient hospice" means a hospice licensed by the Department pursuant to A.R.S. §§ 36-405, 36-422 and A.A.C. Title 9, Chapter 10, Article 8 providing 24-hour inpatient care.
O. "Level of Care" means categorizing patient services according to the type of care provided by the health care institution. Patient care factors, such as nursing hours, physical assistance or administration of medications, may be assigned numeric values generating accumulated or weighted points used to apply charges.
P. "Managed Care" means services delivered to clients through a health maintenance organization, preferred provider organization, third-party administrator or an independent physician association.
Q. "Material" means a significant change in revenue or expense in relation to total revenue or significant changes that affect how a facility is managed or controlled.
R. "Natural Classification" means the classification of expenses as reported on the income statement; i.e., the nature of the items as accrued, such as, salaries/wages, benefits, supplies, purchased services, insurance, and depreciation.
S. "Nonexpendable" means those reusable items that may be rented or sold to the patient. This may include durable medical equipment.
T. "Pass through" means any outside service or purchased commodity that is charged to a patient at the health care institution's cost.
U. "Private payor" means an individual or insurance company responsible for the payment of services. Third-party government payor programs are not considered private payors.
V. "Rate or Charge" means a separate dollar amount levied to a patient for use or consumption of a unit of service or commodity.
W. "Related Party" means an investor (individual, partner or corporation) having more than 5% ownership of another entity.
X. "Senior Plan" means contracted managed care services that are an alternate method of delivering services to Medicare-eligible clients.
Y. "Service" means a unit of care such as a procedure, test, or commodity for which a separate rate or charge is made to a patient.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-102. Annual Filing of Operating Statements and Reports

A. Every hospital, nursing care institution and inpatient hospice shall submit to the Director not later than 120 days following the institution's fiscal year end the following statements and reports for the reporting year:
1. Hospitals shall file:
   a. A report of an audit by an independent certified public accountant conducted in accordance with generally accepted auditing standards in the format defined in A.R.S. § 36-125.04(B).
   b. A copy of the hospital's annual Medicare Cost Report.
   c. A copy of the uniform accounting report pursuant to R9-11-201.
2. Nursing care institutions (NCI) shall submit a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set as their uniform accounting report, and a copy of the annual Medicare Cost Report. The ARSNIC report shall be submitted to the Department in electronic and paper copy format.
3. Inpatient Hospice: Revenue, patient statistics, and expenses related to operating an inpatient hospice shall be

delineated either in the Medicare Cost Report for Hospitals or ARSNIC for Nursing Care Institutions.

B. The Director may grant a 30-day extension in writing in advance of the due date of any required reports. The health care facility shall request such extension in writing at least 30 days prior to the due date pursuant to A.R.S. § 36.125.04. The request for extension of time shall include the following:
1. Name and address of the facility,
2. Reason for the request,
3. Requested due date,
4. Name(s) of the operating statements or reports for which an extension is being requested.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-103. Filing of Rates and Charges

A. Each hospital, nursing care institution, supervisory care facility, and home health agency shall file with the Department all schedules of rates or charges, and other information specified in subsection (F) of this rule. This information shall be regarded as the existing schedule of rates or charges for such institutions.

B. A new hospital, nursing care institution, supervisory care facility or home health agency shall not engage in business within this state until its schedule of rates or charges has been filed with the Department and reviewed as provided in A.R.S. § 36-436 et seq.

C. No rate or charge for a new service or procedure shall be implemented by a hospital or nursing care institution until the requirements of A.R.S. § 36-421 and § 36-436 have been completed in accordance with the following:
1. Rates or charges for a new service or procedure not requiring a permit pursuant to A.R.S. § 36-421 shall be filed with the Director and accompanied by a per-unit cost analysis using direct expense by natural classification, and number of units anticipated over a 12-month period. The Director may issue written findings. Upon submission of all required information, rates will be effective no later than 60 days subsequent to the filing. A schedule of rates and charges for a new service not requiring a permit shall be submitted no more than once quarterly.
2. Rates or charges for a new service or procedure requiring a permit pursuant to A.R.S. § 36-421 shall be accompanied by an analysis consisting of two consecutive 12-month periods projecting each of the following elements:
   a. Volume in units,
   b. Gross Revenue,
   c. Deductions from Revenue,
   d. Direct expenses by natural classification, and
   e. Indirect expenses.

D. No decrease or deletion shall be made by any hospital or nursing care institution in any rate or charge until the proposed decrease or deletion has been filed for informational purposes with the Director.

E. Supervisory care and home health agencies shall submit to the Department increases in rates or charges 30 days prior to implementation.

F. All schedules of rates or charges required to be filed shall include each service and item for which a separate charge is made. The schedule of rates or charges must contain the following information:
1. Facility License Number;
2. Facility Name;
3. Table of contents or record layout that defines the order or sort of the information that would enable the Department to easily locate items by charge code within each department;
4. Department Name and Number;
5. Charge Code;
6. Service description;
7. Existing Charge;
8. Proposed Charge;
9. A copy of all rules, criteria and discounts, such as acuity methodology, pricing rationale, and formulae which may in any way change, affect or determine any part of the aggregate of the rates or charges therein or the value of the services or commodities covered by the schedule.

G. The schedule of rates or charges may be submitted in an electronic format if written approval has been granted by the Department prior to submission.

H. Charges for expendable items received from an outside supplier (excluding capital items for which the patient does not acquire ownership), which are generally numerous in quantity and subject to frequent cost changes, such as pharmacy or central supply items, may be listed on the schedule of rates and charges in the form of a formula, provided that the formula is adopted as a rule or regulation of the institution. The formula shall include, but is not limited to, the following elements:
1. The net purchase cost of the item, which shall reflect all invoiced discounts, allowances or rebates.
2. The percent of cost or dollar markup.

I. If the formula method of listing rates and charges is used, the institution is not required to report or file those rate changes resulting exclusively from a change in the net purchase cost of the item to the institution. Any change in other elements of the formula shall constitute a change in the rate schedule and will require filing of the proposed new rate as provided in A.R.S. §§ 36-436.02 and 36-436.03.

J. If a charge is priced for outside services rendered by those individuals licensed pursuant to A.R.S. Title 32 or facilities licensed pursuant to A.R.S. Title 36, Article 4, the schedule of rates and charges shall include the pricing policy or formula.

K. The effective date of a proposed schedule of rates or charges of a new institution or of a change in the schedule of rates or charges of an existing institution shall be as determined by the institution but not earlier than:
1. The date of the findings of the Director, or
2. Sixty days after the date of filing the proposed schedule together with all supporting data required by A.R.S. § 36-436 and subsections (F) through (J) of this Section, whichever occurs first.

L. The filing date shall be determined by the Department as defined in R9-11-105 and R9-11-107.

M. If increased rates or charges are not reflected on the patient bills along with discounts, if any, within 30 days after the review period has expired, the institution abandons its right to implement the increased schedule of rates or charges unless

written consent is granted by the Director prior to the expiration of the 30-day period.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-104. Filing for Review of Proposed Rate Increases – Hospitals

A. Hospitals shall submit a completed Form 301 (Exhibit 1) as revised June 1, 1993, which is incorporated by reference herein, does not contain any later amendments or editions, and is on file with the Office of the Secretary of State.

B. A hospital may apply in writing to the Department for a waiver from completing Form 301. The hospital shall document in the application that the following apply:
1. Common ownership is shared with another Arizona licensed facility.
2. The hospital has been approved by the Health Care Financing Administration for one Medicare provider number or revenue and expenses are reported as a subprovider on the Medicare Cost Report of the related facility.
3. The hospitals share a common charge master.

C. Each waiver granted under subsection (B) may be revoked by the Director when the Department determines that material changes have occurred which merit separate reporting. Judgments as to materiality shall be based on the Department's knowledge of the hospital. The Department shall notify the hospital in writing of the waiver revocation 120 days prior to the end of the hospital's fiscal year.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-105. Financial Report for Hospital Rate Changes; Preparation and Filing Instructions

A. Form 301 shall be prepared and filed with the Department by hospitals proposing increases in rates and charges pursuant to A.R.S. § 36-436.

B. No proposed rates shall be charged to patients until the Director has issued findings on the proposed increase or 60 days have elapsed from the date of a complete filing, whichever occurs first.

C. A complete rate package shall include:
1. A complete and accurate Form 301.
2. A schedule of the rates and charges as defined in R9-11-103.
3. Written justification for a rate increase and the planned date of implementation.
4. The pricing policy of the hospital for establishing rates.
5. The hospital cost containment program for the Projected Year and a quantified estimate of economic savings for the Base Year.
6. Financing information or a prospectus and applicable debt retirement schedules, if new debt has been incurred or the current debt has been refinanced since the last rate review filing.
7. A copy of the current management agreement and lease, if applicable.
   a. Details of management fees or corporate cost allocations from a home office including the allocation or charge methodology for each function or service.
   b. Details of lease expenses paid to a related party for property, plant and equipment, submitted with Form 301 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principal payments) for the applicable assets.

D. All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-102 and R9-11-105(C) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been obtained from the Department. Form 301 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all required information.
1. Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.
2. The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:
   a. A modification to the schedule of proposed rates and charges.
   b. A change in annual revenue that exceeds 0.5% of the original submittal.
   c. A change in annual operating expense that exceeds 0.5% of the original submittal.
   d. A modification of the Statement of Cash Flows.

E. The following instructions shall apply to the preparation of Form 301:
1. Each hospital shall submit a completed Form 301 to the Department in an electronic format supplied by the Department.
2. If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.
3. No printed line item descriptions, titles, or column headings shall be altered or changed.
4. An institution may supplement Form 301 with additional information necessary to justify the proposed increase.
5. Financial amounts shall be rounded to the nearest dollar amount.

6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.
7. If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.

F. When completing Form 301, the hospital shall define any cost center descriptions added in the space provided or group the cost center on a line item with the same unit of measure.

G. The hospital shall report the number of units of service and the definition of each unit by revenue center. The hospital must obtain prior written permission from the Department to use a definition for a unit of service that is different than those listed in Schedule 14 and 15 of Form 301, or to change their definition of a unit of service in any revenue center between reporting periods.

H. For any patient care services provided in alternate areas, the patient days, revenues and costs shall be reclassified to the responsible unit prior to preparing Form 301.

I. The financial and statistical information reported in Form 301 shall be reported on the accrual basis of accounting.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-106. Filing for Review of Proposed Rate Increases - Nursing Care Institutions

Nursing Care Institutions shall submit a completed Form 302 (Exhibit 2) as revised June 1, 1993, which is incorporated by reference herein, does not contain any later amendments or editions, and is on file with the Office of the Secretary of State.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-107. Financial Report for Nursing Care Institution Rate Changes; Preparation and Filing Instructions

A. Form 302 shall be prepared and filed by all Nursing Care Institutions (NCI) proposing increases in rates and charges.

B. A hospital based NCI, licensed for 60 beds or less, may apply in writing to the Department for a waiver from completing Form 302. The waiver request shall be submitted prior to proposing an increase in rates and charges of the NCI. The hospital based NCI shall document in the application that the following apply:
   1. The NCI is separated from the hospital campus by no more than one common public or private thoroughfare;
   2. The hospital includes the NCI as a discrete operating department in the Financial Report for Review of Proposed Rate Increases -- Hospitals, Form 301; and
   3. The NCI charges are included in the hospital's charge master.

C. No proposed rate shall be charged to patients until the Director has issued findings on the proposed increase, or 60 days have elapsed from the date of a completed filing, as determined by the Department, whichever occurs first.

D. A complete rate package shall include:
   1. A complete and accurate Form 302.
   2. Schedule of current and proposed rates and charges for all services rendered to patients according to the NCI's level of care definitions together with a copy of the rules and criteria as defined in R9-11-103.
   3. Written justification for a rate increase and the planned date of implementation.
   4. A copy of the current management agreement and lease, if applicable.
      a. Detail of management fees and corporate cost allocations charged from a home office including the methodology used to determine the allocations and fees.
      b. Details of lease expense paid to a related party for property, plant and equipment, submitted with Form 302 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principle payments) for the applicable assets.

E. All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-107(D) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been obtained from the Department. Form 302 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all the required information.
   1. Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.

2. The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:
   a. A modification to the schedule of proposed rates and charges.
   b. A change in annual revenue that exceeds 0.5% of the original submittal.
   c. A change in annual operating expense that exceeds 0.5% of the original submittal.
   d. A modification of the Statement of Cash Flows.

F. The following general instructions apply to the preparation of Form 302:
1. Each NCI shall submit a completed Form 302 to the Department in an electronic format supplied by the Department and a printout of the report. A manual Form 302 shall be accepted in lieu of an electronic format.
2. If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.
3. No printed line item descriptions, titles, or column headings shall be altered or changed.
4. An institution may supplement Form 302 with additional information necessary to justify the proposed increase.
5. Financial amounts shall be rounded to the nearest dollar amount.
6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.
7. If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.

Historical Note

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R9-11-108. Notification to Residents of Rate Changes Proposed by Nursing Care Institutions

The nursing care institution shall notify each private payor in writing of changes in either rates or services 60 days prior to the date of implementation of the rates and charges. The notice shall include the following:
1. The proposed implementation date.
2. A rate schedule delineating the current and proposed rates and charges for each type of service.
3. If the proposed rate increase exceeds the health care consumer price index criteria pursuant to A.R.S. § 36-436.03(B), the following shall be included:
   a. A statement that the proposed increase exceeds the consumer price index.
   b. A statement in a prominent place that informs the patients of their right to request a public hearing.
   c. The last date that a hearing can be requested per R9-11-109(B).
   d. The Department's current address to which a request for hearing should be sent.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-109. Hearing Process for Nursing Care Institutions Implementing Rate Increases

A. The director shall hold a public hearing when the annualized rate increase exceeds the health care consumer price index criteria pursuant to A.R.S. § 36-436.03, and a person affected by the proposed rate schedule requests a hearing within 30 days of the filing of the proposed rates.

B. When a public hearing has been requested pursuant to A.R.S. § 36-436.03(B), the NCI shall post notice in a prominent place ten days prior to the hearing. The notice shall include the following:
1. A statement of the time and place for the public hearing.
2. A rate schedule delineating the current and proposed rates and charges for all services.
3. A schedule of all matters to be discussed.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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nor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-110. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-111. Repealed

Historical Note
Added Regulation 2-74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-112. Repealed

Historical Note
Added Regulation 2-74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-113. Repealed

Historical Note
Added Regulation 2.74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-114. Repealed

Historical Note
Amended effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-115. Repealed

Historical Note
Repealed effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-116. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-117. Repealed

Historical Note
Department correction of Form number (Supp. 75-1). Amended effective June 30, 1987 (Supp. 87-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the

Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-118. Repealed

Historical Note

Department correction of language of Regulation heading, Department correction of subsections (B) through (H). Initially this material was available upon request; it is now printed in full (Supp. 75-1). Amended effective June 30, 1987 (Supp. 87-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-119. Repealed

Historical Note

Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-120. Repealed

Historical Note

Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-121. Repealed

Historical Note

Department correction of language of regulation heading. Department correction of subsections (B) through (G) initially this materially was available upon request, it is now printed in full (Supp. 75-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

ARTICLE 2. UNIFORM ACCOUNTING SYSTEM

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-201. Uniform Accounting – Hospitals

Each general hospital, special hospital or infirmary licensed by the Department, unless exempt by A.R.S. § 36-125.04(I), shall, for each fiscal year, file a completed Uniform Accounting Report (Exhibit 3) not later than 120 days following the institution's fiscal year end.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-202 Uniform Accounting -- Nursing Care Institutions

Each nursing care institution shall, for each fiscal year, file a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set (Exhibit 4) not later than 120 days following the institution's fiscal year end.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-203. Reserved

R9-11-204. Reserved

R9-11-205. Reserved

R9-11-206. Reserved

R9-11-207. Reserved

R9-11-208. Reserved

R9-11-209. Reserved

R9-11-210. Reserved

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Gover-

nor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-211. Repealed

Historical Note

Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-212. Repealed

Historical Note

Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-213. Repealed

Historical Note

Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

ARTICLE 3. HOSPITAL DISCHARGE REPORTING FOR INPATIENTS

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules.

R9-11-301. Definitions

In this Article, unless the context otherwise requires:

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "AHCCCS/Medicaid" means care provided pursuant to A.R.S. § 36-2905.
3. "AHCCCS Health Group" means reimbursement for care provided to non-AHCCCS eligible clients but who are enrolled with the AHCCCS through their employer health group plan.
4. "BPI" means bits per inch.
5. "Charity" means reduction in charges for services made by the health care institution because of the indigence of the patient but does not include Title XIX, AHCCCS, contractual obligations of the facility, or other third-party payor settlements.
6. "EBCDIC" means extended binary coded decimal interchange code.
7. "E code" means the environmental events, circumstances, and conditions that caused the injury, poisoning, and other adverse effects.
8. "Foreign national" means reimbursement of a hospital for care provided to another country's national health care system client.
9. "HMO" means a health maintenance organization.
10. "Home IV provider" means individuals or organizations who assist in the delivery of drugs and devices to patients pursuant to A.R.S. Title 32, Chapter 18.
11. "Hospital identification number" means the federal tax identification number.
12. "ICD" means international classification of diseases.
13. "Medicare risk" means contracted services provided by a HMO that represent an alternate method to the federal system of delivering services to individuals 65 and over.
14. "Patient" means a person who is admitted to the hospital as an inpatient only.
15. "Patient certificate/social security number" means an insured's unique identification number utilized by the payer organization.
16. "Patient control number" means the medical record number or other hospital-assigned number for patient identification purposes.
17. "Payer code" means the expected primary source of payment for the majority of the charges associated with treatment.
18. "Physician number" means the state license number of an individual licensed pursuant to A.R.S. Title 32.
19. "PPO" means a preferred provider organization.
20. "Self pay" means payment made directly by the patient, guarantor, relatives, or friends for a patient who does not have medical insurance.
21. "SNF" means a skilled nursing facility pursuant to A.R.S. Title 36, Article 7.
22. "Total patient charges" means the gross charges incurred by a patient that are billed by the hospital.

Historical Note

Adopted effective May 22, 1989 (Supp. 89-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). New Section adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

Editor's Note: The following Section was adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on these rules.

R9-11-302. Reporting Requirements

A. Each hospital shall report statistical and demographic information, as specified in subsections (B) through (E), to the Department for each patient discharged by the hospital, in accordance with the following schedule:
1. For each patient discharged between January 1 and June 30, the information shall be submitted by August 15; and
2. For each patient discharged between July 1 and December 31, the information shall be submitted by February 15.

B. Hospitals shall report to the Department the diagnosis, procedures, and revenue codes pertaining to each discharged patient in a uniform format as specified by the UB-92, National Uniform Billing Data Element Specifications, October 8, 1993, Arizona Hospital Association, 1501 West Fountainhead Parkway, Suite 650, Tempe, Arizona 85282, incorporated herein by reference and on file with the Office of the Secretary of State.

C. Hospitals shall submit the following data elements for each discharged patient in accordance with the physical layout in the Table included in this Article:
1. Hospital identification number,
2. Patient control number,
3. Patient certificate/social security number,
4. Patient race,
5. Patient street address,
6. Patient city,
7. Patient state,
8. Patient zip code,
9. Patient date of birth,
10. Patient sex,
11. Patient date of admission,
12. Patient date of discharge,
13. Patient discharge status,
14. Diagnostic related group code,
15. Total patient charges,
16. Payer code,
17. Revenue codes:
    a. All inclusive rate,
    b. Room and board - private,
    c. Room and board - two bed,
    d. Room and board - 3 or 4 bed,
    e. Private (deluxe),
    f. Room and board - ward,
    g. Other room and board,
    h. Nursery,
    i. Intensive Care,
    j. Coronary Care,
    k. Special charges,
    l. Incremental charges,
    m. All inclusive ancillary,
    n. Pharmacy,
    o. IV therapy,
    p. Medical/Surgical supplies,
    q. Oncology,
    r. Durable medical equipment (other than renal),
    s. Laboratory,
    t. Laboratory pathology,
    u. Radiology - diagnostic,
    v. Radiology - therapeutic,
    w. Nuclear Medicine,
    x. CT scan,
    y. Operating room,
    z. Anesthesia,
    aa. Blood,
    bb. Blood storage and processing,
    cc. Other imaging,
    dd. Respiratory services,
    ee. Physical therapy,
    ff. Occupational therapy,
    gg. Speech therapy,
    hh. Emergency room,
    ii. Pulmonary function,
    jj. Audiology,
    kk. Cardiology,
    ll. Osteopathic services,
    mm. Ambulance,
    nn. Medical social services,
    oo. MRI,
    pp. Medical/Surgical supplies (Extension of 27X),
    qq. Drugs requiring specific identification,
    rr. Cast room,
    ss. Recovery room,
    tt. Labor/Delivery,
    uu. EKG/ECG,
    vv. EEG,
    ww. Gastrointestinal services,
    xx. Treatment/observation room,
    yy. Lithotripsy,
    zz. Inpatient renal dialysis,
    aaa. Organ acquisition,
    bbb. Miscellaneous dialysis,
    ccc. Psychiatric treatment,
    ddd. Psychiatric services,
    eee. Other diagnostic services,
    fff. Other therapeutic services,
    ggg. Professional fees (96X),
    hhh. Professional fees (97X),
    iii. Professional fees (98X),
    jjj. Patient convenience items,
    kkk. All other not covered in (a) through (jjj),
18. Physician name,
19. Physician number,
20. Physician licensing board,
21. Other physician name,
22. Other physician number,
23. Other physician licensing board,
24. Type of admission,
25. Source of admission,
26. Principal diagnosis,
27. Second diagnosis,
28. Third diagnosis,
29. Fourth diagnosis,
30. Fifth diagnosis,
31. Sixth diagnosis,
32. Seventh diagnosis,
33. Eighth diagnosis,
34. Ninth diagnosis,
35. External causes of injury (E code),
36. Second external cause of injury (E code),
37. Principal procedure date,
38. Principal procedure,
39. Second procedure,
40. Third procedure,
41. Fourth procedure,
42. Fifth procedure,
43. Sixth procedure, and
44. Newborn birth weight.

D. Hospitals shall provide the information required in subsection (C) to the Department in the following format:
1. Medium - Untitled, 9 track, 1/2 inch tape
2. Bits per inch - 6250
3. Record length - 694 characters

4. Blocksize - 27760 characters
5. Data format - Extended Binary Coded Decimal Interchange Code

E. The Director shall approve an exception to the format described in subsection (D) in accordance with the following:

1. A hospital shall submit a written request to use an alternate format 90 days prior to the next due date.
2. The alternate format shall include:
   a. Name of the software program that the data is to be submitted in, and
   b. A written description of the file layout.
3. The request shall include a test sample of discharge information as specified in subsection (C).
4. The Department shall notify the hospital of its decision not less than 60 days prior to the next due date for filing the report.

F. The Director shall revoke, in writing, 120 days prior to the next submission date, an alternate format granted under subsection (E) when the Department determines that it can no longer convert the submitted information into a usable file format.

Historical Note

Section adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

TABLE 1. MAGNETIC TAPE SUBMISSION – REQUIRED DATA ITEMS AND FORMAT SPECIFICATIONS FOR INPATIENT DISCHARGES

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
10	1-10	Hospital ID - Federal Tax No	5	Alpha-Numeric	All digits must be filled in. Do not change ID without prior permission from DHS.
17	11-27	Patient's Medical Record Number	23	Alpha-Numeric	Must be filled in. Right justified with leading zeros.
19	28-46	Certificate, Social Security Number, or Health Insurance Claim Number	60	Alpha-Numeric	Must be filled in. Right justified
1	47	Patient Race	-	Race 1 = American Indian, Aleut, Eskimo 2 = Asian, Pacific Islander 3 = Black 4 = Caucasian, Hispanic 5 = Caucasian, Non Hispanic 6 = Other 9 = Refused	Must be entered.
30	48-77	Patient Street Address	13	Alpha-Numeric	Must be filled in.
20	78-97	Patient City	13	Alpha-Numeric	Must be filled in.
2	98-99	Patient State	13	Alpha-Numeric	Must be filled in.
10	100-109	Patient's Zip Code	13	Alpha-Numeric	Postal zip code for the patient's residence at the time of admission. If zip plus four is used indicate as XXXXX-YYYY. Must be filled in. If a foreign resident, fill in with name of the country.
8	110-117	Patient's Date of Birth	14	Enter month-day-year, without dashes MMDDYYYY	All digits must be filled in. If any portion of birthday is unknown enter all zeros for the birthday.
1	118	Patient's Sex	15	Patient's Sex M = Male F = Female	Must be filled in.
8	119-126	Date of Admission	6	The month, day and year of the patient's admission to the hospital. MM-DD-YY	All digits must be filled in including dashes.

8	127-134	Date of Discharge	6	The month, day and year of the patient's discharge from the hospital. MM-DD-YY	All digits must be filled in including dashes.
2	135-136	Patient's Discharge Status	22	The circumstances under which the patient left the hospital: 01 = Discharged to home or self care. 02 = Discharged/transferred to another short-term general hospital. 03 = Discharged/transferred to skilled nursing (SNF). 04 = Discharged/transferred to an intermediate care facility (ICF). 05 = Discharged/transferred to another type of institution. 06 = Discharged/transferred to home under care of organized home health service organization. 07 = Left against medical advice. 08 = Discharged/transferred to home under care of a Home IV provider. 20 = Expired. 09 = All Other	Must be filled in. Right justified with a leading zero. Zero if unknown.
3	137-139	DRG Code	78	The condition established after study as being chiefly responsible for the admission of a patient to the hospital for care.	All digits must be filled in. Right justified with leading zeros.
7	140-146	Total Charges	47	The total gross charges incurred by the patient. Hospital charges only.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.

2	147-148	Payer Code	50	The expected source of payment for the majority of the charges associated with this treatment. 00 = Self pay 01 = Commercial (Indemnity) 02 = HMO 03 = PPO 04 = AHCCCS Health Care Group 05 = Medicare 06 = AHCCCS/Medicaid 07 = CHAMPUS/ MEDEXCEL 08 = Children's Rehabilitation Services 09 = Workers' Compensation 10 = Indian Health Services 11 = Medicare Risk 12 = Charity 13 = Foreign National 14 = Other	Must be filled in. Right justified with leading zeros.

6		Revenue Codes	42	Total gross charges for each revenue code.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.
	149-154	All inclusive rate	10x		
	155-160	Room and board - private	11x		
	161-166	Room and board - two bed	12x		
	167-172	Room and board - 3/4 bed	13x		
	173-178	Private (deluxe)	14x		
	179-184	Room and board - ward	15x		
	185-190	Other room and board Nursery	16x		
	191-196	Intensive Care	17x		
	197-202	Coronary Care	20x		
	203-208	Special charges	21x		
	209-214	Incremental charges	22x		
	215-220	All inclusive ancillary Pharmacy	23x		
	221-226	IV therapy	24x		
	227-232	Medical, surgical supplies	25x		
	233-238	Oncology	26x		
	239-244	DME (other than renal)	27x		
	245-250	Laboratory	28x		
	251-256	Laboratory pathology	29x		
	257-262	Radiology - diagnostic	30x		
	263-268	Radiology - therapeutic	31x		
	269-274	Nuclear Medicine CT scan	32x		
	275-280	Operating room Anesthesia	33x		
	281-286	Blood	34x		
	287-292	Blood Storage/Processing	35x		
	293-298		36x		
	299-304	Other imaging	37x		
	305-310	Respiratory services	38x		
	311-316	Physical therapy Occupational therapy	39x		
	317-322		40x		
	323-328		41x		
	329-334		42x		
	335-340		43x		

	341-346 347-352 353-358 359-364 365-370 371-376 377-382 383-388 389-394 395-400 401-406 407-412 413-418 419-424 425-430 431-436 437-442 443-448 449-454 455-460 461-466 467-472 473-478 479-484 485-490 491-496 497-502 503-508 509-514 515-520 521-526	Speech therapy Emergency room Pulmonary function Audiology Cardiology Osteopathic services Ambulance Medical social services MRI Med/Surg (Ext. of 27x) Drugs required specific ID Cast room Recovery room Labor / Delivery EKG / ECG EEG Gastrointestinal services Treatment / Observation room Lithotripsy Inpatient renal dialysis Organ acquisition Miscellaneous dialysis Psychiatric treatment Psychiatric services Other diagnostic services Other therapeutic services Professional fees Professional fees Professional fees Patient convenience items All other	44x 45x 46x 47x 48x 53x 54x 56x 61x 62x 63x 70x 71x 72x 73x 74x 75x 76x 79x 80x 81x 88x 90x 91x 92x 94x 96x 97x 98x 99x -		
22	527-548	Physician Name	82	Attending physician's name. Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.
6	549-554	Physician State License No.	82	Attending physician's or other practitioner's Arizona License Number.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha-numeric (locum tenens).
1	555	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
22	556-577	Other Physician Name	83	Primary procedure physician's name Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.

6	578-583	Other Physician State License No.	83	Physician, or other practitioner's Arizona License Number who performed the primary procedure.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alphanumeric (locum tenens).
1	584	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
1	585	Type of Admission	19	Indicates the priority (type) of admission: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information not available	Must be filled in. If 4 (newborn), **Source of Admission** must be 1-4, or 9 (unknown).
1	586	Source of Admission	20	Indicates the source of admission - adults and pediatrics: 1 = Physician referral 2 = Clinic referral 3 = HMO / AHCCCS health plan referral 4 = Transfer from a hospital 5 = Transfer from a SNF 6 = Transfer from another health care facility (other than acute care or SNF) 7 = Emergency room 8 = Court / Law Enforcement 9 = Information not available If **Type of Admission** = newborn (4) use: 1 = Normal Delivery 2 = Premature Delivery 3 = Sick baby 4 = Extramural birth 9 = Information not available	Must be filled in.
6	587-592	Principal Diagnosis Code	67	Enter the ICD code describing the condition chiefly responsible for causing this hospitalization.	Left adjust. Must be filled in, including decimal and applicable letter, such as V or E code. Leave blank if unknown. If code consists of less than six places, including the decimal, do not zero fill the blank(s) on the right.

6	593-598	Second Diagnosis	68	Enter the ICD code describing additional conditions	Leave blank if not applicable. Otherwise, left adjust, and include decimal and applicable letter such as V or E code. If code consists of less than six places, including the decimal, do not zero fill the blank(s) on the right.
6	599-604	Third Diagnosis Code	69	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	605-610	Fourth Diagnosis Code	70	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	611-616	Fifth Diagnosis Code	71	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	617-622	Sixth Diagnosis Code	72	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	623-628	Seventh Diagnosis Code	73	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	629-634	Eighth Diagnosis Code	74	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	635-640	Ninth Diagnosis Code	75	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	641-646	External Cause of Injury	77	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
6	647-652	Second External Cause of Injury	-	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
8	653-660	Principal Procedure Date	80	The month, day, and year of the patient's principal procedure MM-DD-YY	All digits must be filled in including dashes.
5	661-665	Principal Procedure Code	80	Enter the ICD code that identifies the principal procedure performed.	Left adjust. Must be filled in, including decimal. Leave blank if unknown. If code consists of less than five places, including the decimal, do not zero fill the blank(s) on the right.
5	666-670	Second Procedure Code	81A	Enter the ICD code describing procedures other than the principal procedure.	Leave blank if not applicable. Otherwise left adjust and include decimal. If code consists of less than five places including the decimal, do not zero fill the blank(s) on the right.
5	671-675	Third Procedure Code	81B	Same as second procedure code.	Same as instructions for the second procedure code.
5	676-680	Fourth Procedure Code	81C	Same as second procedure code.	Same as second procedure code.

5	681-685	Fifth Procedure Code	81D	Same as second procedure code.	Same as second procedure code.
5	686-690	Sixth Procedure Code	81E	Same as second procedure code.	Same as second procedure code.
4	691-694	Newborn Birth Weight	-	Birth weight in grams.	Must be entered for all newborns.

Data Requirements for Reporting Under A.R.S. § 36-125.05:

MEDIUM: 9 TRACK, 1/2 INCH TAPE
BPI: 6250
RECL: 694 CHARACTERS
BLOCKSIZE: 27,760
LABEL: NO LABELS
DATA FORMAT: EBCDIC

MAGTAPE.FN2 (2/2/95)

Historical Note
Adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

ARTICLE 4. OUTPATIENT SERVICES REPORTING

Article 4, consisting of Sections R9-11-401 and R9-11-402, made by final rulemaking at 9 A.A.R. 2105, effective June 3, 2003 (Supp. 03-2).

R9-11-401. Definitions

The following definitions apply in this Article:

1. "Charge" means the same as "rate or charge" in R9-11-101.
2. "Diagnosis" means a determination of an individual's disease, illness, or injury, made by a health care provider authorized by law to make the determination.
3. "Diagnostic-related group code" means a numeric or alpha-numeric identifier that is assigned by the Center for Medicare and Medicaid Services to two or more outpatient services that are provided to an individual with a specific diagnosis.
4. "Governing authority" has the same meaning as in A.R.S. § 36-401.
5. "Hospital" has the same meaning as in A.A.C. R9-10-201.
6. "Hospital identification number" has the same meaning as in R9-11-301.
7. "Outpatient" has the same meaning as in A.A.C. R9-10-201.
8. "Outpatient services" means:
   a. Hospital services as defined in A.A.C. R9-10-201 provided to an outpatient by a hospital; and
   b. Outpatient surgical services as defined in A.A.C. R9-10-1701 provided to an individual by an outpatient surgical center.
9. "Outpatient surgical center" has the same meaning as in A.R.S. § 36-401.
10. "Patient certificate or social security number" has the same meaning as "patient certificate/social security number" in R9-11-301.
11. "Patient control number" has the same meaning as in R9-11-301.
12. "Payer code" has the same meaning as in R9-11-301.
13. "Procedure" means a surgical operation or technique.
14. "Tax ID number" means the numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
15. "Total patient charges" has the same meaning as in R9-11-301.

Historical Note
New Section made by final rulemaking at 9 A.A.R. 2105, effective June 3, 2003 (Supp. 03-2).

R9-11-402. Reporting Requirements

A governing authority of a hospital or an outpatient surgical center shall submit the following information for each outpatient according to the schedule and format requirements in R9-11-302:

1. An identification number as follows:
   a. For a hospital, the hospital identification number; or
   b. For an outpatient surgical center, the outpatient surgical center's tax ID number;
2. The patient control number;
3. The patient certificate or social security number;
4. The patient's address including city, state, and zip code;
5. The patient's date of birth;
6. The patient's sex;
7. The date outpatient services were initiated;
8. The date outpatient services were terminated;
9. The diagnostic related group code;
10. The total patient charges;
11. The payer code;
12. The principal diagnosis;
13. The second diagnosis;
14. The third diagnosis;
15. The fourth diagnosis;
16. The fifth diagnosis;
17. The sixth diagnosis;
18. The seventh diagnosis;
19. The eighth diagnosis;
20. The ninth diagnosis;
21. External cause of injury;
22. Second external cause of injury;
23. The date of the principal procedure;
24. The principal procedure;
25. The second procedure;

26. The third procedure;
27. The fourth procedure;
28. The fifth procedure; and
29. The sixth procedure.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 2105, effective June 3, 2003 (Supp. 03-2).